TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of HEB

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-17-1535-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the applicable Texas fee schedule the correct allowable would be per the DRG 854. The allowable for this DRG per the Medicare is $14,350.61, we have also attached the print out for your review from the Medicare pricer program. The correct allowable would be at 143% making the allowable at $20,521.37. Based on their payment of $20,458.65, there is an additional allowance of 62.72 still due at this time."

Amount in Dispute: $62.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we have determined that not [sic] additional allowance is due."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12 – 15, 2016	Inpatient Hospital Services	$62.72	$62.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z695 – The charges for this hospitalization have been reduced based on the fee schedule allowance
   - B13 – The recommended allowance on this line is based on TX fee schedule reimbursement guidelines

- 193 – The recommended allowance on this line is based on TX fee schedule reimbursement guidelines
- W3 – The recommended allowance on this is based
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeding additional reimbursement of $62.72 for inpatient hospital services rendered from February 12 – 15, 2016. The carrier reduced the billed charges with adjustment code Z695 – "The charges for this hospitalization have been reduced based on the fee schedule allowance."

   The requestor states, "there is an additional allowance of 62.72 still due at this time." The respondent states, "we have determined that not [sic] additional allowance is due." The Division will calculate the allowable based on the following fee guideline.

   Inpatient acute care hospital reimbursement is subject to the provisions of Code 28 Texas Administrative Code §134.404(f), which states

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register.

   Per §134.404(f)(1),

   > The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables.

   Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A and is found below.

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%.

   Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov.

   Review of the submitted medical claim finds that the DRG code assigned to the services in dispute is 854. The services were provided at Texas Health Harris Methodist. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $14,350.61.

   Step 1: Calculate the Medicare facility specific reimbursement amount plus any applicable outlier payment

   The division establishes the total Medicare facility specific amount in this case using the *Medicare Inpatient PPS PC Pricer* as a tool. The *Medicare Inpatient PPS Pricer* efficiently identifies facility specific payment factors and adjustment. The pricer is found at www.cms.gov.

   The following illustrates the division's calculation of the total Medicare facility specific amount:

TOT DRG AMT:	Add back VBP CR *(not applicable due to conflict with Texas Labor Code)*	Add Cost Outlier *(applicable)*	Total Medicare Facility Specific Amount
$14,334.43	+ $16.18	+ $0.00	$14,350.61

Note that a claim reduction identified as "VBP CR" on the *Medicare Inpatient PPS Pricer* was added back into the total DRG amount for this admission. "VBP CR" stands for Value-Based Purchasing (VBP) claim reduction (CR) which in Medicare is used to fund the Medicare VPB program. Medicare's VBP program was implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. Consequently, the Medicare VBP program conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system. The fee rule for inpatient hospital services contains a conflict provision which explains that the Texas Labor Code in such instances takes precedence:

> 28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

For this reason, the VBP CR amount does not apply. The VBP claim reduction amount added back in because it does not apply to inpatient hospital services provided in the Texas Workers' Compensation system.

Step 2: Multiply the total Medicare facility specific amount by 143%

The reimbursement calculation is therefore:

Total Medicare Facility Specific Amount	28 TAC §134.404 (f)	Total DWC Reimbursement
$14,350.61	$14,350.61 x 143%	$20,521.37

The total allowable reimbursement for the services in dispute is $20,521.37. This amount recommended.

3. The total recommended payment for the services in dispute is $20,521.37. The insurance carrier has paid $20,458.65. The remaining balance of $62.72 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $62.72.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $62.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.